TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Amanda McInis, D.C.

Respondent Name
Metropolitan Transit Authority Harris County

MFDR Tracking Number
M4-17-2412-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A referral was established by the treating doctor … for an Alternate opinion regarding MMI/IR and RTW examination as a result of a dispute regarding the opinions of Dr. M. Raper, Designated Doctor Examination dated 06/03/16 for MMI/IR and RTW."

Amount in Dispute: $1150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOB(s) and the reduction rational(s) stated therein … the certification became final on 09/21/16, and the requestor would not be eligible for reimbursement for an MMI and IR evaluation performed on 10/10/16."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2016	Referral Examination to Determine Maximum Medical Improvement, Impairment Rating, and Return to Work	$1150.00	$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on or after September 1, 2016.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for return to work examinations performed on or after September 1, 2016.
4. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 96 – Non-covered charges
   - Comments: DDE performed MMI/IR and addressed RTW on 6/3/16. Per TDI-DWC rules a first certification of MMI/IR must be disputed within 90 days of written notice.
   - W3 – Additional reimbursement made on reconsideration.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - Comments: Per rule 134.804, W3 is to be used when a payment is made following a request for reconsideration. The service adjustment amount associated with this code may be zero. Original payment decision is being maintained.

Issues

1. Is the insurance carrier's reason for denial of payment for procedure code 99456-WP supported?
2. Is the insurance carrier's reason for denial of payment for procedure code 99456-RE supported?
3. What reimbursement is recommended for the disputed services?

Findings

1. Amanda McInis, D.C. is seeking reimbursement of $650.00 for an examination to determine maximum medical improvement (MMI) and impairment rating (IR) represented by procedure code 99456-WP and performed on October 10, 2016. Metropolitan Transit Authority Harris County denied the disputed service with claim adjustment reason code 96 – "Non-covered charge(s)," with further comment, "DDE performed MMI/IR and addressed RTW on 6/3/16. Per TDI-DWC rules a first certification of MMI/IR must be disputed within 90 days of written notice."

   Texas Labor Code §408.0041(f-2) states,

   > An employee required to be examined by a designated doctor may request a medical examination to determine maximum medical improvement and the employee's impairment rating from the treating doctor or from another doctor to whom the employee is referred by the treating doctor if:
   > (1) the designated doctor's opinion is the employee's first evaluation of maximum medical improvement and impairment rating; and
   > (2) the employee is not satisfied with the designated doctor's opinion.

   Documentation submitted with the request for medical fee dispute supports that the examination in question was provided because the injured employee was not satisfied with the designated doctor's opinion, and that the designated doctor's opinion was the first evaluation of MMI and IR.

   Texas Labor Code §408.0041(h)(1) states that the insurance carrier shall pay for "an examination required under Subsection (a), (f), or (f-2), unless otherwise prohibited by this subtitle or by an order or rule of the commissioner." The division finds that the examination in question was not prohibited by the Labor Code, an order, or rule of the commissioner. Therefore, Metropolitan Transit Authority Harris County's denial of this examination is not supported.

2. Dr. McInis is also seeking reimbursement of $500.00 for an examination to determine the injured employee's ability to return to work, represented by procedure code 99456-RE, performed on October 10, 2016. Metropolitan Transit Authority Harris County denied the disputed service with claim adjustment reason code 96 – "Non-covered charge(s)."

   28 Texas Administrative Code §134.235 states, in relevant part, "The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting **a division or insurance carrier requested** (emphasis added) RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier 'RE.'"

   The division finds that the examination in question was not requested by the division or the insurance carrier. Therefore, Metropolitan Transit Authority Harris County's denial of payment for this examination is supported.

3. Per 28 Texas Administrative Code §134.250(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that Dr. McInis performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

   Per 28 Texas Administrative Code §134.250(4), "The following applies for billing and reimbursement of an IR evaluation. … (C)(ii) The MAR for musculoskeletal body areas shall be as follows. … (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation supports that Dr. McInis provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the left shoulder. Therefore, the MAR for this examination is $300.00.

   The total allowable for the disputed services is $650.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $650.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	September 22, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.